IN THE SUPREME COURT OF THE STATE OF DELAWARE

SCOTT PAVEY and VIRGINIA P. PUSPOKI, individually and as The Executors of the Estate of TSURU PAVEY,	§	No. 628, 2009
Plaintiffs Below, Appellants,	§	Court Below: Superior Court of the State of Delaware in and for New Castle County
v.	§	
ERIC D. KALISH, M. D., MICHAEL K. CONWAY, M. D., DELAWARE SURGICAL GROUP, P. A.	§	C.A. No. 05C-09-190
Defendants Below, Appellees.	§	

Submitted: July 7, 2010
Decided: August 23, 2010

Before **STEELE**, Chief Justice, **HOLLAND**, **BERGER**, **JACOBS**, and **RIDGELY**, Justices, constituting the Court *en Banc*.

O R D E R

This 23rd day of August 2010, upon consideration of the briefs of the parties and their contentions at oral argument, it appears to the Court that:

(1) This is a medical negligence and wrongful death action in which the Superior Court entered judgment in favor of Defendants[1] after excluding the

[1] The Defendants are Eric D. Kalish, M.D., Michael K. Conway, M.D., and Delaware Surgical Group, P.A..

testimony of Plaintiffs'[2] medical expert. Appellants contend that the trial court erred when it concluded their expert witness, Neil Novin, M.D., lacked sufficient experience to form a reliable opinion. Appellants further contend that the trial court erred when it granted summary judgment without a written motion and adequate notice. The record reveals that Dr. Novin was an experienced surgeon who had sufficient expertise to form an opinion meeting the threshold for admissibility. Accordingly, we reverse the Superior Court's decision to exclude Dr. Novin's testimony and enter summary judgment for Defendants.[3]

(2) Tsuru Pavey was admitted to Christiana Hospital on June 19, 2003, for treatment of multiple myeloma and sepsis. A central venous catheter (the "Hickman catheter"), used to administer chemotherapy and infuse fluids, was inserted on June 25, 2003, by Eric D. Kalish, M.D. When inserted, the catheter pierced the superior vena cava causing bleeding into the pleural space. The catheter remained plugged in the hole in the vein, preventing further bleeding.

(3) Following the insertion of the Hickman catheter, Ms. Pavey experienced difficulty breathing. Chest x-rays revealed a pneumothorax, which resisted treatment with nasal oxygen. A transesophageal echocardiogram showed a large right pleural effusion and that the Hickman catheter was non-functional. A

[2] The Plaintiffs-below are Scott Pavey and Virginia Puspoki, individually and as the Executors of the Estate of Tsuru Pavey (collectively, the "Appellants").
[3] It is therefore unnecessary to address Appellants' second argument.

chest tube was inserted, and blood and body fluid were drained. Michael Conway, M.D., determined that the catheter was improperly inserted in the right pleural space and required removal. Dr. Conway consulted the attending thoracic surgeon, Allen Davies, M.D., and they determined that the catheter would be removed in a monitored setting.

(4) On June 27, 2003, Dr. Conway directed and supervised the removal of the Hickman catheter in a monitored room with Dr. Kraut, a thoracic surgeon, assisting. Upon removal of the catheter, Ms. Pavey became lightheaded, lost consciousness and could not be resuscitated. Ms. Pavey's death certificate identified "massive intrapleural hemorrhage" as the cause of death.

(5) Plaintiffs' expert, Dr. Neil Novin, opined that the removal of the Hickman catheter should have been performed in an operating room with a thoracic surgeon present, and that Defendants, through their negligence, caused the death of Ms. Pavey. The Defense experts were prepared to testify that the catheter was appropriately removed, that it was appropriate to do so in the monitored setting which was used and that a thoracic surgeon would not have been able to intervene and prevent the patient's death in the manner contended by Dr. Novin. The trial court announced its ruling excluding Dr. Novin as an expert witness with the following explanation:

> The Court: The issue before this Court is whether the witness's testimony that a – that a thoracic surgeon should have been

present in the operating room to do immediate open chest surgery in the event that there was any untoward event is what is at issue here. The witness is a former – is a general surgeon who has not practiced surgery since 1988, almost 20 years, and in formulating his opinion he aggressively states that he didn't consult any literature or conduct any research to determine what the standard of care was with regard to the procedure in question here. He also states that he didn't even discuss the situation with any other surgeon. And he arrives at a conclusion that the Court finds totally surprising; namely, that he expected that if something happened in the operating room, the standby thoracic surgeon would immediately open the patient's chest without any anesthetic. And that is just too startling. Before the Court can allow that opinion to be placed before the jury there has to be some scientific support for it, and this witness provides none. The motion will be granted.

Plaintiffs' Counsel: Your Honor, I just note –

The Court: Is that the only expert you have, [counsel]?

Plaintiffs' Counsel: That is the expert. And I'd ask Your Honor to reconsider that ruling. This is a situation that there is no literature on because –

The Court: I'm not formulating it basically on the literature. I based it one, number one – not number one in particular. That's part of it.

Secondly, this doctor's removal from direct surgical practice for nearly 20 years and the nature of his opinion, which just clashes with all reason and common sense. Before the Court can have that put before the jury I would expect that there would be some better basis than this doctor who just says, "I think that's the way it should have been done." And that's basically all he says. "I think this is the way it should have been done and there should have been a doctor there who could have cut this lady's chest open as soon as soon as she lost consciousness." That makes no sense to this Court.

(6) The record in this case shows the experience, medical practice, hospital privileges, and present tenure of Dr. Novin as a clinical associate professor of surgery at the University of Maryland Medical School. Dr. Novin graduated from State University of New York, Downstate Medical Center in 1955. He

interned in Baltimore, Maryland for one year prior to joining the United States Air Force. He attended Flight Surgeon School, and worked as a flight surgeon with 300 hours flying time. He was Chief of Professional Services at the 18th Tactical Hospital in Okinawa. He was discharged at the rank of Major and returned to Baltimore where he spent four years in a general surgical residency at the University of Maryland, completing the program in 1963. For the next few years, he worked as a professor of anatomy and surgery while he started his own practice.

(7) In 1966, Dr. Novin became Chief of Surgery of South Baltimore General Hospital, now known as Harbor Hospital. He remained Chief of Surgery for more than twenty-one years, and had a full surgical residency. He was responsible for one-third of the general surgical classes' clinical experiences. During this time, Dr. Novin successfully completed the American Board of Surgery examination.

(8) Because of an injury, Dr. Novin stopped performing surgery himself in 1988, but continues to provide surgical consultations, second surgical opinions, care for people with injuries that don't require hospitalization, and consultations on Social Security disability determinations. He retains hospital privileges at the University of Maryland, Mercy Hospital, and Maryland General Hospital. Dr.

Novin is on the honorary staff at Harbor Hospital, and on the consultant staff at Sinai Hospital.

(9) Dr. Novin is currently a clinical associate professor of surgery at the University of Maryland Medical School. At various times during his tenure at the University of Maryland, Dr. Novin was president of the Baltimore Academy of Surgery, president of the University of Maryland Surgical Society, president of the Maryland Chapter of the American College of Surgeons, vice chairman for the Committee on Trauma for the State of Maryland for the American College of Surgeons, and coordinating communicator for the Cancer Commission for the American College of Surgeons.

(10) Dr. Novin is board certified in general surgery, and is a certified specialist in vascular surgery in the State of Maryland.[4] Dr. Novin is a surgical consultant for J. Gaber & Associates, P.A., a medical practice in Baltimore. He also continues to read medical journals. Dr. Novin testified in his deposition that in the course of his career, he estimated that he has opened a patient's chest on an emergent basis six times. In one of these instances, the patient's chest was opened because of a suspected injury to the superior vena cava.

[4] *Balan v. Horner*, 706 A.2d 518, 520 (Del. 1998) (reiterating this Court's holding in *Baoust v. Kraut*, 377 A.2d 4, 7 (Del. 1977), that "the diagnosis and treatment of some medical problems may be of concern to doctors of different specialties, and in an area of concurrent expertise, a common standard of care may be shared.").

(11) When a party offers expert testimony, the court must determine whether the proffered expert's knowledge will assist the trier of fact.[5] If the witness is qualified by knowledge, skill, experience, training or education, he may testify in the form of an opinion or otherwise.[6] The proponent of the expert testimony bears the burden of establishing that the testimony is relevant and reliable by a preponderance of the evidence.[7] There is a "strong and undeniable preference for admitting any evidence having some potential for assisting the trier of fact."[8] "Expert opinions are appropriate where they will assist the jury in understanding the facts or the evidence."[9]

(12) The trial court relied on its finding that Dr. Novin lacked sufficient experience to form a reliable opinion, and its assessment of the merit of Dr. Novin's opinion. The duty of the trial court is not to determine "which theory is stronger" but instead to act as a "gatekeeper" who determines whether the testimony is based on sufficient facts or data and on reliable principles and

[5] D.R.E. 702 ("If scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training or education may testify thereto in the form of an opinion or otherwise, if (1) the testimony is based upon sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.").
[6] *Id.*
[7] *Sturgis v. Bayside Health Ass'n Chartered*, 942 A.2d 579, 584 (Del. 2007).
[8] *DeLuca v. Merrell Dow Pharmaceuticals, Inc.*, 911 F.2d 941, 956 (3d Cir. 1990).
[9] *Ward v. Shoney's, Inc.*, 817 A.2d 799, 803 (Del. 2003).

methods that have been reliably applied to this case.[10] We review the Superior Court's decision to exclude Dr. Novin's expert testimony for abuse of discretion.[11] The duty to exercise discretion "generally includes the duty to make a record to show what factors the trial judge considered and the reasons for the decisions."[12]

(13) In light of Dr. Novin's experience and credentials, we conclude that the Superior Court abused its discretion in excluding his testimony which met the threshold for admissibility under D.R.E. 702. Although Dr. Novin did not conduct a literature search prior to formulating his opinion in this matter, all experts in this case have agreed that there is no medical literature directly addressing the standard of care for removal of the Hickman catheter under the circumstances of this case. Further, Appellants presented sufficient evidence to establish that Dr. Novin was qualified by knowledge, skill, experience, training or education to offer an opinion on the issue of the standard of care for the removal in an operating room of a Hickman catheter that has punctured a patient's superior vena cava. In his deposition, Dr. Novin was asked to "identify each breach of the standard of care that you contend occurred starting with the first one and ending with the last one." He testified in response:

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[10] D.R.E. 702; *.G. Bancorporation v. Le Beau*, 737 A.2d 513, 521-23 (Del. 1999); *accord Kumho Tire Co. v. Carmichael*, 526 U.S. 137 (1999).
[11] *M.G. Bancorporation*, 737 A.2d at 522.
[12] *Storey v. Camper*, 401 A.2d 458, 466 (Del. 1979).

> My basic criticism is that this young lady had a misadventure when the catheter inadvertently traversed the vena cava and was free in the pleural cavity, an accident that's rare, and I don't consider that a breach of the standard of care. It's an accident that happened, it was recognized, it was somewhat delay [sic] in the recognition, but again, I don't think that had a deleterious effect. It just delayed the proper removal, it resulted in her bleeding into her chest and getting excess fluid in her chest.
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> A chest tube was properly placed. There was [sic] some problems with that getting loose, but that, too, my main criticism is that the catheter went through a major blood vessel and was functioning as a plug in a hole or a finger in the dike. We knew that there was massive bleeding into the chest and removing that catheter ran a significant risk of what ultimately happened. She bled to death.
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> She should have been taken to an operating room with a competent orthopedic surgeon – correction – competent thoracic surgeon present so that when the catheter was removed and the plug removed and she bled, she could have been operated on, had a finger put in, a stitch put in, and she would have probably been with us today.
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> So, my criticism is that she was put in a monitored bed to monitor that which was unnecessary to monitor. She belonged in an operating room so that when the catheter was removed and the possible and significant probable bleeding would occur, proper care could have been rendered. It was not, and she died.

(14) As an experienced general and vascular surgeon and as a clinical associate professor of surgery, Dr. Novin addressed the standard of care for removal of the Hickman catheter where it is known that the catheter pierced the superior vena cava and the patient had already lost two liters of blood prior to the removal of the catheter. After reviewing the facts of this case, Dr. Novin formed an opinion based on his knowledge and experience that such removal should have been done in an operating room with a thoracic surgeon present to prevent her

from bleeding to death. Because his testimony satisfied the threshold for admissibility under D.R.E. Rule 702, the Superior Court abused its discretion in excluding Dr. Novin's testimony and in entering summary judgment for Defendants.

NOW, THEREFORE, IT IS ORDERED that the judgment of the Superior Court is **REVERSED** and this matter is **REMANDED** for further proceedings consistent with this Order.

BY THE COURT:

/s/ Henry duPont Ridgely
Justice